THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2
Rev. 1985
Rev. 1993
Rev. 2005

STATE OF ALABAMA

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Ombudsman 1-800-528-5166

CLAIM REFERENCE

1. Insured Report Number	2. Claims Administrator Claim Nbr	3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name 5. Physical Address 1 6. Physical Address 2 7. City 8. State 9. Zip	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS 10. Mailing Address 1 11. Mailing Address 2 12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number	17. NAICS

INSURER / CLAIMS ADMINISTRATOR

18. Insurer Name 19. Insurer Federal ID Number 20. Insurer Type Code	21. Administrator Name 22. Mailing Address 1 23. Mailing Address 2 24. City 25. State 26. Zip 27. Administrator Federal ID Number

EMPLOYEE / WAGES

28. First Name 29. Middle Name 30. Last Name 31 Last Name Suffix (ie. Jr., Sr., III)	32. Employee ID Number 33. ID Type Qualifier SSN ☐ Passport Number ☐ Green Card ☐ Employment Visa ☐ Assigned by Jurisdiction ☐
34. Mailing Address 1 35. Mailing Address 2 36. City 37. State 38. Zip 39. Phone	40. Gender Male ☐ Female ☐ 41. Date of Birth (ccyymmdd) 42.Nbr of Dependents
43. Marital Status Single ☐ Divorced ☐ Widowed ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown ☐	44. Date Hired (ccyymmdd)
45. Occupation Description	46.Number of Days Worked Per Week
47. Wages $ 48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐	49. Received Full Pay For Day of Injury? Yes ☐ No ☐ 50. Did Salary Continue? Yes ☐ No ☐

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE 56. Site Address 57. City 58. State 59. Zip 60. County	61. Injury Occurred on Employer's Premises? Yes ☐ No ☐ 62. Date Employer Notified (ccyymmdd)

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES TO IDENTIFY SOURCE OF INJURY, PART OF BODY THAT WAS AFFECTED AND NATURE OF INJURY.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// DIR.ALABAMA.GOV/DOCS)

64. Nature of Injury 65. Part of Body 66. Cause of Injury

67. Initial Treatment First Aid By Employer ☐ Emergency Room ☐ Hospitalized > 24 Hours ☐	No Medical Treatment ☐ Minor Clinic / Hospital ☐ Hospitalized Overnight ☐ Outpatient Treatment ☐	68. Name of Treatment Facility 69. Address 70. City 71. State 72. Zip

73. Name of Physician or Other Health Care Professional	74. Has Injured Returned to Work Yes ☐ No ☐	If so, 75. Date 76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared (ccyymmdd)	78. Preparer's First Name 79. Last Name 80. Title	81. Preparer's Phone